

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 44 BOARD OF DENTAL EXAMINERS

Chapter 30 Record Keeping

Authority: Health Occupations Article, §4-205(c)(3), Annotated Code of Maryland

.01 Scope.

A. This chapter covers the production and maintenance of patient records by dentists in any form or medium.

B. The following is not governed by this chapter:

- (1) Retention schedules of dental records;
- (2) Confidentiality of dental records;
- (3) Disclosure of dental records;
- (4) Requests for copies of dental records;
- (5) Concealment of dental records;
- (6) Destruction and disposal of dental records; and
- (7) Requirements imposed by:
 - (a) 45 CFR Part 160, as amended; and
 - (b) 45 CFR Part 164, as amended.

.01-1 Definitions.

A. In this chapter the following terms have the meanings indicated.

B. Terms Defined.

(1) “Best practices” means a method or technique that through experience and research has shown to reliably lead to results superior to those achieved by other means.

(2) “Electronic health records” means health records created and maintained on computer or other electronic device.

.02 General Provisions for Handwritten, Typed, and Electronic Health Records.

A. A dentist shall create and maintain a separate dental record for each patient.

B. Dental records shall include:

- (1) A patient’s clinical chart as described in Regulation .03 of this chapter; and
- (2) Financial records as described in Regulation .04 of this chapter.

C. Dental records may be:

- (1) Handwritten in ink;
- (2) Typed; or
- (3) Generated on a computer or other electronic device.

D. Dental records may not be created or maintained in pencil.

E. If treatment is rendered, dental records shall be made contemporaneously with the treatment rendered.

F. Dental records shall be created and maintained for each individual seeking or receiving dental services, regardless of whether:

- (1) Any treatment is actually rendered; or
- (2) Any fee is charged.

G. All entries shall be dated.

H. Electronic Health Records.

(1) A dentist who creates and maintains electronic health records shall utilize best practices related to:

- (a) Hazard and risk analysis and mitigation;
- (b) Software development;
- (c) Validation;
- (d) Maintenance;
- (e) Security measures; and
- (f) System integration and operation.

(2) A dentist who creates and maintains electronic health records shall maintain a back-up copy of the records and, if feasible, a back-up copy off site.

(3) The initials and signatures in electronic health records required by this chapter may be produced electronically.

(4) Electronic health record systems shall include an audit-trail function that details all interactions between systems and their users and all interactions among systems.

(5) The audit-trail identified in §H(4) of this regulation shall include:

- (a) Attempted or successful unauthorized access to the electronic health records where the determination is feasible;
- (b) Attempted or successful unauthorized modification or destruction of any records where the determination is feasible;
- (c) Interference with application operations of the electronic records;
- (d) Any setting of or change to logical access controls related to the dispensing of controlled substance prescriptions; and
- (e) Attempted or successful interference with audit trail functions.

(6) Electronic health record systems shall provide the capability to produce a hard copy business version of each treatment or progress note and shall indicate:

- (a) The date and time of each entry;
- (b) The identity of each individual who made the entry;
- (c) The method used in the creation of each entry, which shall include but not be limited to:

- (i) Direct entry via keyboard or mouse;
- (ii) Speech recognition;
- (iii) Automation;
- (iv) Machine-entered default information;
- (v) Pre-created documentation via form or template;
- (vi) Copy or import of an object including the date and time of the entry and the identity of the original author;
- (vii) Copy forward previous note contents including the date and time of the entry and the identity of the original author; and

(viii) Dictation and transcription from an external system.

I. A dental record shall contain:

- (1) The patient's name or other patient identifier;
- (2) If the patient is a minor, the name and address of the patient's parents or guardian;
- (3) The patient's address and telephone number;
- (4) The patient's date of birth;
- (5) The patient's place of employment if the patient wishes to provide the information;
- (6) Emergency contact information;
- (7) Medical and dental histories which shall be updated at each visit; and
- (8) Insurance information.

J. To the extent practicable, each document in the dental records shall contain one or more patient identifiers.

K. Dental records shall:

- (1) Be accurate;
- (2) Be detailed;
- (3) Be legible;
- (4) Be well organized; and
- (5) Document all data in the dentist's possession pertaining to the patient's dental health

status;

L. Entries shall be signed or initialed by the individual who provided the treatment.

M. With the exception of dental hygienists, entries made by auxiliary personnel shall be:

- (1) Reviewed by the treating dentist; and
- (2) Signed or initialed by the treating dentist.

N. Entries made by individuals other than the individual who provided the treatment shall:

- (1) Identify the individual who made the entry;
- (2) Identify the individual who provided the treatment;
- (3) Be signed or initialed by the individual who provided the treatment; and
- (4) Be signed or initialed by the treating dentist.

O. Exception. Entries made by an individual other than the individual who provided the treatment may not require the signature or initials of the treating dentist if the treatment was provided by a dental hygienist.

P. A dentist and auxiliary personnel may not erase, alter, obliterate, or "white out" dental records.

Q. Blank spaces may not be left between entries.

R. Changes to handwritten and typed dental records shall:

- (1) Be made by a single line strike-through of the incorrect entry so that the incorrect entry may be read;
- (2) Contain changes in the corresponding margin or in close proximity to the incorrect entry;
- (3) Be dated;
- (4) Be signed or initialed by the treating dentist; and
- (5) If the change was made by auxiliary personnel:
 - (a) Be reviewed;
 - (b) Be approved; and
 - (c) Be signed or initialed by the treating dentist.

S. The dental records shall contain only those abbreviations that are commonly acceptable within the profession and comprehensible to other dentists.

T. Except for notations of payment or failure to make payment, financial records may not be maintained in the clinical chart.

U. Dentists are responsible for the content of the dental records.

V. A dentist who has been issued a dispensing permit by the Board shall maintain dispensing records in accordance with Regulation .03J of this chapter.

.03 Clinical Charts.

A. Each patient's clinical chart shall include at a minimum the following:

- (1) Patient's name and date of treatment;
- (2) Reasons for the patient's visit;
- (3) Treatment plans that are signed and dated by both the treating dentist and the patient;
- (4) Patient's complaints;
- (5) Diagnosis and treatment notes;
- (6) Progress notes;
- (7) Post operative instructions;
- (8) Study models;
- (9) In-person conversations, telephone conversations, and other correspondence with the patient or their representative;
- (10) Identification of medications prescribed, administered, dispensed, quantity, and directions for use;
- (11) Clinical details with regard to the administration of:
 - (a) Nitrous oxide;
 - (b) Anxiolytics;
 - (c) Sedation; and
 - (d) General anesthesia.
- (12) Radiographs of diagnostic quality;
- (13) Periodontal charting;
- (14) Laboratory work authorization forms and correspondence to and from laboratories;
- (15) Informed consent;
- (16) Copies of correspondence and reports provided to other health care providers, diagnostic facilities, and legal representatives;
- (17) Records and reports provided by other health care providers and diagnostic facilities;
- (18) Details regarding referrals and consultations;
- (19) Patient complaints pertaining to the dentist and staff, and their manner of resolution;
- (20) Noncompliance and missed appointment notes; and
- (21) Dismissal letter.

B. A dentist who performs diabetes or blood pressure screening shall include the results of the screenings in the patient's clinical chart.

.04 Financial Records.

A. Financial records shall be considered part of the dental records but shall be maintained separately from the patient's clinical chart.

B. Financial records shall include at a minimum the following:

- (1) Complete financial data concerning the patient's account, including:
 - (a) Each amount billed to or received from the patient or third-party payor; and
 - (b) The date of each bill and each payment;
- (2) Copies of all claim forms submitted to third-party payors by the dentist or by the dentist's agent or employee; and
- (3) Payment vouchers received from third-party payors.

.05 Violations.

Failure to comply with this chapter constitutes unprofessional conduct and may constitute other violations of law.

Administrative History

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